OFFICE OF THE MAYOR
THE CITY OF NEW YORK

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DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

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Medicaid.gov
Center for Medicaid and CHIP Services
Center for Medicare and Medicaid Services
7500 Security Blvd, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850
https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1888355

RE: Medicaid 1115 Demonstration – New York Partnership Plan (11-W-00114/2) Amendment

Dear Sir/Madam:

The City of New York submits the following comments in support of the Medicaid Section 1115 Demonstration Partnership Plan Waiver amendment submitted by New York State Department of Health (NYSDOH) to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2016.

Broadly, we feel that New York's proposed 1115 waiver will help improve health for justice-involved individuals reentering community settings. As explained below, we have a few additional suggestions that we believe would strengthen NYS DOH's amendment further and enhance the availability of health services.

Background

Under New York state law, Medicaid coverage is suspended for individuals who are incarcerated for 30 days or more and reinstated on the first day of the release month.[1] However, many continue to experience obstacles and delay in reinstating their Medicaid coverage and have trouble finding health care providers after their release.[2] The lapse in access to care has a particularly disruptive impact on the health of recently incarcerated individuals, as they are more likely to have chronic physical or mental health conditions. Research has shown that individuals face a markedly increased risk of death—as high as 12.7 times that of the general population—during the first two weeks after release.[3] Drug overdose is the

[1] N.Y. C.L.S. Social Services Law §366.
[2] Mallik-Kane, K., Visher, C.A., Health and Prisoner Reentry: How Physical, Mental and Substance Abuse Conditions Shape the Process of Reintegration, Urban Institute (Washington D.C: 2008).
[3] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, 356(2), 157-165.

leading cause of death for this population, representing nearly a quarter of all deaths post-release.[1] Mental illness is also highly prevalent—New York City data show that 25% of the incarcerated population in the city is assessed to have some form of mental health diagnosis and 4.5% of the inmate population is designated as seriously mentally ill.[2]

New York State has the largest number of HIV-infected incarcerated individuals, constituting approximately 15% of the total HIV-infected incarcerated population in the U.S.[3] The infection rate of Hepatitis C virus (HCV) among New York state inmates was estimated to be 10.1%,[4] more than 6 times higher than the same for the general public (1.6%),[5] and NYC data show that the highest average annual rate of new HCV diagnoses in NYC occurred in the incarcerated population (964.3/100,000 people).[6] New York City neighborhoods where incarcerated individuals have been shown to return to upon release are also those with the highest reporting rates of HCV (East and Central Harlem, South Bronx, Bed-Stuy, Brownsville, East New York), and some of these neighborhoods have little available medical services for HCV. In addition, these are areas with high rates of HCV among their Latino (31%) and Black (30%) populations. In New York City, 11,500 people of color living with HIV had also been diagnosed with HCV infection as of the end of 2013. Studies show that minority populations have much less access to medical care, and HCV treatment, in particular, than other populations and can benefit from the assistance of linkage-to-care services. Because HCV-infected patients and those co-infected with HIV often have other co-morbidities, staying in care, completing the HCV medical evaluation, and completing treatment may be difficult in the absence of additional supportive services and linkage to care that could be obtained from the waiver. The current standard of care for HCV is an 8-12 week regimen of various directly-acting antiviral agents (DAAs) that are notoriously extremely expensive. Beginning this regimen when an inmate is incarcerated only to discontinue it will render the treatment ineffective, and it cannot be started again from the point at which it ended. The patient will, in most cases, have to begin treatment after a complete medical evaluation. An additional risk from not ensuring continuity is that a lapse in HCV treatment may increase the likelihood that drug resistance will develop, potentially causing the treatment to fail and creating new and even more costly challenges for the healthcare system.

New York City also continues to have one of the highest rates of tuberculosis (TB) in the U.S. with over twice the national rate (7.1/100,000 versus 3.0/100,000 persons).[7] In 2015, Sunset Park, East Harlem, and West Queens had the highest TB case rates with East Harlem experiencing a 98% increase in their TB rate from 2014 to 2015. Twenty-one percent of TB patients live in neighborhoods with very high area-based poverty (30% or more persons living below the federal poverty level). In 2015, 6% of all patients with TB disease were known to be HIV-infected. The NYC jail system, the 2nd largest jail system in the U.S., conducts comprehensive screening for tuberculosis infection and disease at jail admission. Every year, NYC jails identify detained persons who test positive for latent TB infection or have signs/symptoms/diagnostic testing indicative of active TB. All of these patients require 1) linkage to primary care in the community; 2) reliable access to medications for treatment of their latent or active TB; 3) regular clinical monitoring including symptom review, physical exam, laboratory and radiography

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[1] *Id.*

[2] *Mental Illness in Correctional Settings*, New York State Assembly Committee on Correction (2014) (testimony of Homer Venters, MD, Assistant Commissioner of Correctional Health Services, New York City Department of Health and Mental Hygiene), available at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/testimony_committee_on_correction.pdf

[3] Laura M. Maruschak, Table 1, HIV in Prisons 2001-2010, Bureau of Justice Statistics, U.S. Department of Justice, available at https://www.bjs.gov/content/pub/pdf/hivp10.pdf

[4] Alvarez KJ, Befus M, Herzig CT, Larson E. Prevalence and correlates of hepatitis C virus infection among inmates at two New York State correctional facilities. *J.Infect Public Health.* 2014;7:517–521.

[5] Armstrong G., Wasley A., Simard E., McQuillan G., Kuhnert W., Alter M.; The Prevalence of Hepatitis C Virus Infection in the United States, 1999 through 2002. *Ann Intern Med.* 2006;144:705-714.

[6] New York City Department of Health and Mental Hygiene. Bureau of Communicable Disease Surveillance Data (2014-2015).

[7] New York City Department of Health and Mental Hygiene. Bureau of Tuberculosis Control Annual Summary, 2015.

evaluation to monitor progress/side effects of medications, and, for active TB, case management, and care coordination to ensure and document treatment adherence and completion. TB is a serious, communicable public health condition that, if left untreated or inadequately treated, results in higher morbidity and mortality and risk for disease transmission to household, work, or school contacts. The standard treatment for active TB disease is six months of multiple TB drugs. Uninterrupted treatment is essential to ensure patients do not develop drug resistance strain of TB which is harder and longer to treat. For latent TB infection, a shorter treatment regimen (3-4 months) is available; however, it can be costly. It is important that patients have continuous access to treatment regimens to prevent progression from latent infection to active TB disease. Similar to HIV and HCV, TB elimination efforts depend on enhanced detection and effective treatment of all TB-infected persons and require linkage to primary care in the community, reliable access to medications for treatment of their condition, and case management and care coordination.

As noted above, continuous access to health care providers and medications is particularly important for the vulnerable population of justice-involved individuals. Florida requires Medicaid managed care plans to develop agreements with correctional facilities to anticipate the release of individuals who were enrolled in Medicaid prior to incarceration. Once such individuals are released, the managed care plans are required to (1) provide psychiatric services to enrollees within 24 hours after release; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; and (3) conduct outreach to enrollees at risk and encourage them to access healthcare services. A study conducted in Florida and Washington found that having Medicaid enhanced the inmates' utilization of mental health services upon release from jail[8] In addition, having Medicaid at the time of release, especially coupled with access to mental health services and substance abuse counseling, was associated with a 16% reduction in the average number of subsequent detentions.[9]

Comments

- The City acknowledges the many challenges in defining a jail population's 30-day pre-release period, specifically for the detained population. However, we believe that local jails should not be excluded from this authorization as the impact across the state will be far greater if re-entry for this population is improved. At a minimum, the jail sentenced population should be included in any initial phase, while NYS works with localities to develop acceptable ways to qualify the entire jail population for these benefits.
- As a correctional health provider, New York City Health + Hospitals Correctional Health Services (CHS) does not bill third party payors for the services it provides. We, therefore, believe that an alternative to fee billing for specific services or procedures should be adopted for purposes of this waiver, and suggest a methodology similar to the Certified Public Expenditure methodology. We believe that the City's certified, Medicaid-allowable direct and indirect costs incurred as a result of the provision of care under this waiver should be claimed as expenditures of the State's Medicaid program and thereby be rendered eligible for federal financial participation (FFP). In addition, we believe that the State should provide, in its waiver request, for a pass-through of FFP to the City. In this way, the State would not incur any new expenditure, and the City would receive no greater funding than it would have received had it billed individual claims to Medicaid, under a fee schedule well-calibrated to cost.

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[8] Morrissey, J. P., Steadman, H. J., Dalton, K. M., Cuellar, A., Stiles, P., & Cuddeback, G. S. (2006). Medicaid enrollment and mental health service use following the release of jail detainees with severe mental illness. *Psychiatric services*, 57(6), 809-815.

[9] Morrissey, J. P., Cuddeback, G. S., Cuellar, A. E., & Steadman, H. J. (2007). The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. Psychiatric Services, 58(6), 794-801.

- It is important to consider the feasibility of providers to participate in in-reach activities, focusing on provider capacity and financial demands related to the expectation to meet and establish relationships with incarcerated consumers prior to discharge. While the proposal to leverage videoconferencing may have promise, it should be noted that instituting videoconferencing may entail technological and administrative challenges for providers as well as judicial and correctional institutions.
- We recommend that prerelease enrollment and care management services by Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) providers be covered, as these entities are often providing an even higher level of case management than health home care managers.
- Finally, we strongly believe that the New York City jail system should be included in the first phase of a Medicaid waiver implementation. According to New York State's own data, New York City accounted for over one-third of the 193,349 total annual discharges from jails in New York State. New York City had 64,699 discharges in the same year when New York State saw 25,019 discharges from its system. In addition to the size of the City's incarcerated population, the more transient jail compared to prison population argues for early and immediate benefit from this waiver. As part of the largest public health care system in the nation, CHS not only has its comprehensive clinical service and robust discharge planning and re-entry programs, but also has strong and close connections to the health home and full-service community-based ambulatory care, inpatient and post-acute networks of NYC Health + Hospitals. All of these together point to the greater likelihood of care continuity and successful maintenance in the community of patients who can receive enhanced services prior to release under this waiver.

We appreciate the opportunity to provide our comments regarding these proposed regulations.

Sincerely,

Herminia Palacio, MD, MPH
Deputy Mayor for Health and Human Services